Southington Public Schools
Southington, Connecticut

Authorization for Medication Administration by School Personnel

Connecticut State Law requires a written order from an authorized prescriber (MD, DDS, OD, DO, PA, APRN or for interscholastic and intramural athletic events only - DP.) and parent/legal guardian/eligible student (18 years old or emancipated minor) authorization for both prescription and non-prescription medications. All medications shall be delivered to the school by the parent, guardian, eligible student or other responsible adult. The medication must be stored in the original labeled container as dispensed from the pharmacy or in the unopened over the counter packaging. No more than a three month supply of medication may be left at school.

Name of Student:_____ DOB: _____ Grade: _____

Trade Name of Medication: _____Generic Name of Medication: _____

Dosage: _____ Route of Medication: _____

Frequency/Time in School: _____

Reason for Medication: _____

Possible Side Effects and Management: _____

_____

Known Allergies:_____

Dates to be Administered: From: _____ To: _____ Is this a controlled drug? ☐ Yes ☐ No

If not a controlled drug, this student is capable and authorized to self-administer this medication: ☐Yes ☐ No

If **Yes**, prescriber training is required:

Student has been trained in self-administration of this medication in prescriber's office: ☐ Yes ☐ No

☐ I do ☐ I do not wish that the medication be administered on field trips and shortened days.

Special Instructions: _____

Signature: _____ **(Physician/Authorized Prescriber)**

Address: _____ Phone: _____ Date: _____

****

Parent/Legal Guardian or Eligible Student Authorization

I hereby give my permission for qualified school personnel to administer to my child the medication ordered above by his or her authorized prescriber (MD, DDS, OD, DO, PA, APRN or for interscholastic and intramural athletic events only- DP.) Any misuse of this medication will result in disciplinary consequences following the Southington Board of Education policy and procedure. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of school whichever comes first.

I give permission for the release and exchange of information between the school nurse and authorized prescriber necessary to ensure the safe administration of such medication.

Signature of Parent/Legal Guardian/Eligible Student: _____

Date:_____ Home Phone: _____ Cell Phone: _____

****

School Nurse Authorization

Self-administration of some medication may be authorized by the authorized prescriber and parent/legal guardian/eligible student. The Self-Administration Assessment and Contract has been reviewed by the school nurse in accordance with Southington Board of Education policy/procedure.

School Nurse review for self-administration: ☐ **Yes** ☐ **No:** _____

RN Signature: _____ Date: _____